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Constructionist Provocations for Therapeutic Conversations about Sexuality

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Abstract

In this article I attempt to deconstruct our dominant discourse about sexuality, with special emphasis on sexuality as a topic within the psychotherapeutic context. As a social constructionist, my concern is with the ways in which people coordinate their activities together to produce particular beliefs and values (otherwise referred to as “realities”). The beliefs and values we articulate concerning sexuality, then, are not universally or objectively true. Instead, they are constructed byproducts of social relationships which are historically, culturally, and locally situated. What is central, to the constructionist, in both the case of psychotherapy and sexuality, is the issue of meaning; the meaning of both psychotherapy and of sexuality. I offer a very brief overview of the individualist tradition that dominates the profession of psychotherapy, followed by an overview of the constructionist alternative to individualism and end with some implications for our understanding and practice of psychotherapy as it relates to the issue of sexuality.

Scenario 1: A friend telephones seeking support for the latest in a, not unusual, round of marital differences. Her partner wants more sex. She is uninterested. This is a common presenting issue in marital therapy or, if not the presenting issue, often part of a complex web of complaints the couple brings to therapy.

Scenario 2: A young woman initiates therapy because she finds herself attracted to other women. This realization frightens her and she is now seeking to explore, in therapy, possible treatments for her problem.

Scenario 3: A professional, well educated woman calls for an appointment with a psychotherapist because cuddling, kissing, holding hands and touching her 13 and 15 year old children are very important to her. However, she knows that her friends and neighbors see this behavior as unhealthy for her children and perhaps even evidence of her own sexual problems [1].¹

In this article I would like to deconstruct our dominant discourse about sexuality, with special emphasis on sexuality as a topic within the psychotherapeutic context. As a social constructionist, my concern is with the ways in which people coordinate their activities together to produce particular beliefs and values (otherwise referred to as “realities”). The beliefs and values we articulate concerning sexuality, then, are not universally or objectively true. Instead, they are constructed byproducts of social relationships which are historically, culturally, and locally situated.

I will attempt in this article to clarify some of the naïve understandings of constructionism while using the issue of sexuality and its treatment in the psychotherapeutic context as an illustration. By so doing I hope to clarify the constructionist stance, transform our understanding and approach to sexuality and psychotherapy, and ultimately provide resources for generative dialogue on this topic.

¹ This scenario is based on an article appearing in *The New York Times* (Sunday, December 4, 2005).

I make no attempt here to cover the history of sexuality in psychotherapy, nor provide detailed examinations of various psychotherapeutic models and their treatment of sexuality and sexual issues. Rather, my aim is to introduce the notion of psychotherapy as a process of social construction and consider how this stance provides alternative understandings of sex and sexuality in the therapeutic context.

When psychotherapy is understood as a process of social construction [2, 3], we deviate in generative ways from traditional understandings of therapeutic process and its purpose. Constructionism embraces the value-invested commitments of our ways of talking and, by association, illustrates the ways in which particular talk about sexuality in psychotherapy becomes an option for personal, relational and social transformation. This orientation stands in contrast to the more traditionally accepted view that claims any psychotherapeutic understanding of sexuality is scientifically based and therefore objectively reflects the way things are. The constructionist, by contrast, recognizes that the way things are is a byproduct of social engagement. Meaning and reality (values and beliefs) emerge within communities where people coordinate their activities together. Thus, in the psychotherapeutic context, therapist and client work together to construct generative and transformative possibilities. This view challenges our taken for granted ideas about the “expert” professional who provides an objective diagnosis and designs the “correct” treatment plan.

What is central, to the constructionist, in both the case of psychotherapy and sexuality, therefore, is the issue of meaning. What is the meaning of psychotherapy? To most, psychotherapy is associated with the medical profession. It is a context where diagnosis and treatment are prioritized. Further, what is the meaning of sexuality? Is it an inevitable part of human nature that must be contained, controlled and used auspiciously? Is it a social, cultural problem? Let me begin by offering a very brief overview of the individualist tradition that dominates the profession of psychotherapy. I

will follow this overview with the constructionist alternative to individualism and end with some implications for our understanding and practice of psychotherapy as it relates to the issue of sexuality.

Individualism and Psychological Pathology

Let us consider for just a moment the specific ramifications of individualist discourse in the context of psychotherapy. At stake here is the dominating factor that psychotherapy, as a profession, provides diagnosis for a person's psychological distress. While it is the case that there are many modes of psychotherapy where emphasis is placed on moving beyond personal or psychological distress, the profession requires first and foremost that a diagnosis be identified before moving toward problem resolution or treatment. In fact, because psychotherapy is tightly linked to the medical profession, the overwhelming belief is that psychotherapy, in order to proceed, demands diagnosis. How could a therapist know how to treat a client if that therapist was operating without a clear idea of what the client's problem was in the first place? To treat a problem then requires diagnosis. Two issues are relevant here: (1) the issue of diagnosis as it relates to individualism and therefore the implication that deficiency resides within the person requiring individual diagnosis and (2) the issue of diagnosis as a necessary conversation (particularly in psychotherapy) that revolves around identification of problems, the causes of the problems, and the resolution of problems. These issues are not necessarily separable. Let me expand on each to set the context for a relational (constructionist) alternative to diagnosis.

Diagnosis of individuals. Central here is the observation that diagnosis in psychotherapy means diagnosis of an individual. If one's identity is located within the person, as individualism tells us, then all that is problematic must emanate from the internal mind or psyche of that person. Thus the diagnosis must be of the person, of the individual. There are certainly situations where such diagnosis can be useful. Consider the varying responses different people might have to the diagnosis of chronic

depression. For some, learning from the “expert” (i.e., psychotherapist) that they are suffering from chronic depression can be helpful. The diagnosis gives them the sense that now that the problem has been identified, a treatment program can begin. There is hope in sight. Yet we must not forget all those others for whom the diagnosis of chronic depression (or any other diagnosis) initiates a tailspin into further malaise. Armed with the diagnosis, these people lose hope by virtue of being identified as flawed, inferior, unhealthy, and anything but “normal.”

Diagnosis requires problem talk. Psychotherapy, diagnosis and problems are terms that naturally go together. We seek psychotherapy when we feel uneasy, unsettled, or disturbed. Things are not going well in our lives and psychotherapy is one of the central places we turn for help. Given this assumption, it is difficult to imagine the utility of a psychotherapeutic conversation where the central topic of discussion is not problem oriented. Yet, therapy as social construction presses the therapeutic conversation in entirely different directions. Might both client and therapist gain by initiating conversation about valued and reliable resources for action that the client harbors? What stories can be told that illustrate these valued resources? If the client were to imagine that she or he was able to draw on those resources at will, what would be the activities in which she or he might no longer be engaged? What new activities might she or he be inviting others to co-construct? In these resource-focused conversations, diagnosis is stripped of its power. If a client can talk with a therapist and others about potentials and possibilities, s/he might no longer need to focus attention on his or her deficits. Or, more likely, conversation about the relational resources a client already has successfully constructed with others might suggest that these same resources could be usefully recruited into the relationships where problems have become the byproduct of coordinations with others.

Without claiming that diagnosis is wrong or bad, let me shift my focus now to the ways in which diagnosis invites us into debilitating patterns of relationship. My colleague Kenneth Gergen and

I have discussed some of the deleterious byproducts of diagnosis elsewhere [4]. Let me quickly review these detrimental patterns here. These limitations of diagnosis illustrate both individualism and problem talk as potential barriers to the generation of potentials for social transformation.

The Debilitating Possibilities of Diagnosis

First, there are ways in which diagnosis becomes stigmatizing for the individual. The field of psychology in general and psychotherapy in particular, carries with it an implicit set of values. There are ways of being in the world that are preferred over others. So, for example, when a therapist attempts to help a homosexual client “adjust” to the heterosexual world s/he lives in, that therapist is implicitly re-constructing the hegemony of heterosexuality. A therapist who agrees to help the mother described in the third, opening scenario create “appropriate boundaries” between herself and her children has failed to question the taken-for-granted assumption that physical autonomy and independence from parents are necessary and important for a child’s development.

Most important is the observation that when we diagnose (or agree to “treat”) a client, we enter into a value-laden conversation. It is not, as scientific discourse would claim, value neutral. Diagnosis does not simply describe what is there. Rather, diagnosis functions as a moral judgment. It conveys the person’s deficit to others (mostly experts and family members). Consider the first scenario opening this essay. Any assessment of a married couple’s frequency of sexual activity carries a value bias. And, these biases are not uniform. Ponder the most common perspectives on this issue: (1) men only think about sex and (2) women do not enjoy (or need) sex. To cast men as “sexually hungry” ignores those males for whom sex is reserved for procreation. To view women as uninterested in sex is to pathologize those who are eager to be sexual. Let us explore further. Culturally and historically young girls are warned that sex is dangerous and that only “bad girls” think about sex, talk about sex, or become sexually active. The dominant discourse about sex tells young girls that being intrigued or

curious about sexuality – a stance that most anyone would accept as natural – is akin to aligning oneself with prostitutes and whores.² “Good” girls are not interested.

With such a powerful cultural narrative, complimented by the male counterpart which praises men for their sexual explorations, is it any wonder we have the sort of complaint described in the first scenario with such astounding frequency? The communities, of which we are part, construct completely opposing values and beliefs for women and men concerning sexuality. Rather than pathologize men and women for particular ways of relating, wouldn't an exploration of a reconstructed sense of sexuality be generative? What if sex and sexuality were not taboo topics but, rather, celebrated topics that mark our human diversity? The moment a person enters therapy to discuss issues of gender identity, marital sexual frequency, or the need to have physical contact with one's adolescent children, that person is acting into (and therefore benignly contributing to) the construction of a context that acts “as if” there could be one normative mode of sexuality.

Added to the problem of stigmatization is the impulse to blame the person for his or her failings. Elsewhere I have talked about the ways in which individualism invites us into patterns of blame and evaluation [5]. If my actions are motivated by my internal, individual beliefs, values, and commitments, then any flaw or deficit must also be seen as residing within and thus I am held responsible for my actions. If I am responsible for my actions and they are deemed wrong or bad or inappropriate, then I am the only one to blame. My dysfunction is located within me. My failing is my inability. Within this logic, I am likely to withdraw from others so as not to inflict my problems on them. Others then become evaluators (“She's at it again”) and thus engage in conversations of blame as well. There is little room here for exploration into external factors that might contribute to the deficiency.

² Much should be said, as well, about the cultural narratives surround prostitution, but that is not the scope of the present paper.

Thus, as diagnosis proceeds, relationships are torn apart. If I have a problem (particularly one that has been diagnosed) then I must work it out myself. Those closest to me are probably those who I am most likely to protect from my problem. Why burden my loved ones with my deficiencies? And, if it is my loved ones who are constructed as the “cause” of my problem, then all the more reason to avoid them. As I seek help from mental health professionals, my dearest family and friends are advised to stay away and let the “professional do his or her job.” If I believe my problem stems from my marriage, I seek council from my therapist rather than my spouse. My different perspective on sexuality now becomes my problem rather than a topic for conversation with those most affected by my view. We immediately move into the logic of good/bad, right/wrong which reduces conversation rather than encourages it. In this way, the mental health profession at large and the process of diagnosis and treatment actually inhibits the growth and evolution of relationships ranging from intimate to community to organizational ties.

With the deterioration of relationships we begin to see how our sense of community is depleted. The lack of community naturally limits our attention to traditions, rituals, and folkways that previously have bound us together. When in need, I am more likely to turn to the mental health professional for help than to a person or group of people with whom I share religious beliefs, professional interests, or any leisure activities. And the more I depend on the psychological professional to help me, the more I contribute to placing community and relationships at the boundary.

Finally, the discourse of diagnosis that is pervasive in the profession of mental health provides the individual with little in the way of resources for moving on in life. Think of how nationally sanctioned mental health care, for example, controls how much help we can receive and how we will receive it. Managed care also identifies those issues for which we need professional help, thereby categorizing some as more seriously troubled than others. We now have an enormous array of

professionals making decisions about a person's life, thereby disempowering the person him or herself. As Foucault [6] points out, when we offer ourselves for professional examination, we are giving ourselves over to the disciplinary regimes (in this case the mental health professionals and administrators) to be labeled and explained in their terms. As we do so, we carry these terms into other realms of our daily life. We speak to others now of our depression, our sexual dysfunction, our gender confusion, our anxiety, our stress, our attention deficit; each one a technical term constructed by professionals. As we use these terms in our common parlance, we engage in relationships wherein we extend control to those professionals to dictate the ways we talk about ourselves. Professionals then begin to influence policy and practice amongst the general public and we become further controlled in their terms [7].

Hoeg [8], in his novel exploring the lives of three children living at an experimental, residential school where they were constantly being assessed by the "authorities," summarizes the problems we face with diagnosis (assessment).

When you assess something, you are forced to assume that a linear scale of values can be applied to it. Otherwise no assessment is possible. Every person who says of something that it is good or bad or a bit better than yesterday is declaring that a points system exists; that one can, in a reasonably clear and obvious fashion, set some sort of a number against an achievement.

But never at any time has a code of practice been laid down for the awarding of points . . . Never at any time in the history of the world has anyone . . . been able to come up with a code of practice that could be learned and followed by several different people, in such a way that they would all arrive at the same mark. Never at any time have they been able to agree on a method for determining when one drawing, one meal,

one sentence, one insult . . . is good or bad or better or worse than another . . . (pp. 78-79)

Hoeg's position gives us reason to consider alternatives to diagnosis.

The Constructionist Alternative

In what follows I attempt to lay out relational alternatives that might supplement our individualist traditions. Are there ways of relating – of talking and doing – that privilege relations over individuals and in so doing provide opportunities for transformation even around such taboo topics as sexuality? After all, psychotherapy is focused on transformation. How can a relational sensitivity provide resources for acting in the psychotherapeutic context – resources that are generative and transformative?

Of course, not all diagnosis is damaging. For some diagnosis serves as an aid in moving on in one's life. My argument here is not to abandon diagnosis but to augment this (largely) unquestioned cultural practice with an alternative. The alternative that I would like to suggest is that of relational engagement. With emphasis on what people do together, the negative effects of diagnosis can be lessened.

To the constructionist, meaning emerges as communities of people coordinate their activities with one another. The continual coordination required in any relationship or community eventually generates a sense of common practices, a vocabulary if you will. The patterns or rituals that emerge within relationships or communities generate standards over time. There are standards of expectation and standards of value. We come to expect the enactment of given patterns (e.g., for lovers who have constructed a pattern of daily sexual intimacy, a day of abstinence is likely to raise concern; against the cultural norm of heterosexuality, homosexuality becomes the deviation; and placing value on symbolic forms of nurturing between a mother and her children, the nurturance afforded through physical

connection becomes a barrier to “normal” development of the children). We also implicitly construct a set of values associated with our own and others’ performances (e.g., daily sex is a good thing; heterosexuality is normal; emotional, not physical, nurturance leading to the autonomy necessary for survival in adult life). As these standards emerge and the coordinated activities become more and more entrenched within the relationship or community, a way of life is established – actually appearing as if “natural” and “normal” and transcendent of time or place or persons. This is a reality *achieved* through coordination of activities within a relationship. But we must be clear: it is “as real as it gets.”

Important to note here is that this process transpires within all communities and relationships. Thus, the potential for incommensurate life-worlds is enormous. For each community that constructs sexuality, for example, as a natural, human activity, there are other communities that construct sexuality as illustrative of all that is messy and uncivilized about humanity. It is difficult to imagine how these communities could have any form of productive talk with one another. If the two opposing communities were to engage in conversation about the nature and value of sexuality, the conversation would quickly dissolve into a debate with each community invested in persuading the other of their Truth. Debate and persuasion, we might note, invite antagonism and the quest for objectivity. If I feel that my preferred way of thinking about and approaching sexuality has been demonized, I am hardly likely to remain in relation to those who attack my beliefs and values. We are left with little possibility for going on together as Wittgenstein [9] would say.

Recognizing that there are multiple and diverse rationalities, each gaining coherence within its own community, is the first step toward transformation of social practice. When we think of this in relation to diagnosis the question is, can we imagine listening to the stories of our clients in therapy not for purposes of locating those stories within some diagnostic category but rather for purposes of granting coherence to the difficulty that has brought the client to therapy? In other words, how does

the client's story grant a situational coherence to activities that, placed in some broader social context, might be negatively assessed. Does the client's story of gender identity sound "pathological" only in the context of the culture at large but render complete comprehension within the microcosm of relations within which the client locates herself? Discussions that invite these stories give voice to the complexity and locality of social life and thereby open new resources for engaging in that life.

If we talk about meaning as a byproduct of our coordinations - our joint actions - with others, then what is the job of the therapist? More generally, what does the field of psychology, from this relational orientation, offer? Social construction, with its relational focus, presents a challenge to traditional notions of expert knowledge and professional neutrality.

Meaning is inevitably a function of the cultural traditions, local conventions, and historical canons. We are faced with the question of how to live together in a complex world inhabited by so many differing beliefs, truths, values, and forms of practice. What is "acceptable," "normal," "good," "right" is not easy to determine because we must always inquire into whose standards for acceptable, normal, good or right we are privileging. And, in so doing, whose standards are we oppressing. The task at hand is one of coordination, and our curiosity is drawn to therapy as a site of coordinated meaning making.

In the remainder of this article I will explore some resources that move us beyond the negative consequences of diagnosis and toward potentials for action in the realm of psychotherapy. These resources, I should add, all center on embracing *what people do together* as the focal point.

Toward Inquiry of Potential and Possibility

I would like to provoke a broader conversation in the realm of psychotherapy. Must diagnosis be the focal point of therapy? Who benefits from such a focus? Clearly, the psychological professionals responsible for developing the diagnostic criteria benefit in terms of professional

advancement. Additionally, for those diagnoses requiring or suggesting medical treatment, the large pharmaceutical companies stand to gain. As well, some who seek psychotherapy benefit from diagnosis. Yet, as our culture becomes more and more immersed in practices of assessment and evaluation (diagnosis) – all offspring of modernist science – we find ourselves hard pressed to find forms of practice that inspire potential and possibility by drawing on resources for action already available in relationships.

And yet, new efforts are emerging in small pockets, each attempting in their own ways to revitalize the positive potential of social life. For example, Martin Seligman's positive psychology [10], the appreciative inquiry method developed by David Cooperrider [11] and the work of Cooperrider and Dutton [12] on cooperation and global change, performative approaches to psychology [13], articulations of collaborative education [14], as well as a host of other projects. The move to embrace human potential, to focus on what is working as opposed to what is not working, and focus on the future as opposed to the past are exciting new trends. To place our focus within these domains, we invite ourselves to construct more livable stories with our clients. That is, we emphasize what we *do* together (embodied activities) as primary rather than emphasizing what we assume to be inherent characteristics of people. The focus is on *language practices* – not on qualities of persons. In any given moment, there are multiple resources for action and each of these resources has the potential to generate wholly different realities, possibilities, and constraints.

I would like to identify three conversational themes that could usefully focus our attention on a constructionist form of relational engagement: (1) employing familiar conversational resources in

unfamiliar settings (2) focus on the future, and (3) languaging³ the ideal. I will illustrate the ways in which such a focus can transform our approach to sexuality in the psychotherapeutic context.

Using familiar resources in unfamiliar places. Tom Andersen [15] describes the therapist's job as introducing not too much change and not too little change but just enough change. He echoes Bateson's well-known phrase, "the difference that makes a difference" [16]. Here, I am suggesting a variation on this common theme. We all carry with us many voices, many differing opinions, views and attitudes - even on the same subject. These voices represent the accumulation of our relationships (actual, imagined, and virtual). In effect, we carry the residues of many others with us; we contain multitudes [17]. Yet, most of our actions, along with the positions we adopt in conversations, are one dimensional. They represent only a small segment of all that we might do and say. The challenge is to draw on these other voices, these conversational resources that are familiar in one set of relationships and situations but not in another. In so doing, we achieve just enough difference as Tom Andersen proposes.

Using familiar resources in contexts where we do not generally use them invites us into new forms of relational engagement with others. If we think of all our activities as invitations into different relational constructions, then we can focus on how utilizing particular resources invites certain responses/constructions in specific relationships and how it invites different responses and different constructions in others. All represent various attempts to achieve coordinated respect for the specificity of a given relationship and situation. Let me elaborate by focusing attention, for the moment, on the issue of professional identity.

³ I use the term languaging here to emphasize the *activity* of relational engagement and to distinguish this constructionist notion of language from the traditional view that language is an object of sorts (a system of symbols) that is used to represent the world.

We inherit from modernist discourse the expectation (assumption) that there is a proper way to be a professional therapist. We often see this in trainees when they begin seeing clients. They are more likely to talk as they believe a therapist should talk thereby ignoring those conversational resources that are familiar and unique to each of them (i.e., the way they might talk with a friend, a family member, or a co-worker about a difficulty for example). Trainees' ideas about how a therapist should talk will vary, of course, by tradition. It might be paraphrasing (What I hear you saying is...), it might be empathizing (Oh, that must be quite difficult...), it might be interpreting (What that really means is...). Trainees are actually in the process of adding these "professional" conversational moves to their already developed repertoire. This is not necessarily a problem except to the extent that, in so doing, they silence the very ways of relating that are most comfortable, familiar, and thus natural for them. The familiar becomes alienated and what has previously been alien (e.g., being a "therapist") is miraculously supposed to be instantly familiar!

If we can encourage ourselves (and others) to draw broadly on the conversational resources that are already familiar, perhaps we can act in ways that are just different enough to invite others into something beyond the same old unwanted pattern. Can a therapist recall a time when she was genuinely curious about another's beliefs – beliefs that were so alien and perhaps even incomprehensible? What if this therapist suspended her professional assessment that mothers should have less physical contact with older children thereby allowing them to individuate and develop "normally?" What if, instead, this therapist embraced genuine curiosity and engaged in conversation with this mother about her views of the positive and generative aspects of maintaining a strong physical form of nurturance with her children? To the extent that we can invite the use of the familiar in unfamiliar contexts, we are coordinating disparate discourses. What we are avoiding is co-opting

one discourse as right and another as wrong. The novelty of enacting the old in a new context becomes, I believe, fertile soil within which to craft generative transformation.

Focus on the future. If you examine the field of psychotherapy, you will note that a good deal of therapy talk hovers on the past. Therapists and clients alike explore the history and evolution of the problems that clients bring to therapy. When did the problem begin? How long has it been a difficulty? How have you come to understand (make sense of) the problem? What do you think causes the problem? What do others say about it (and you)? What have you done to try to solve this problem? The questions that therapists ask direct the therapeutic conversation to the past, as do the expectations that many clients bring to therapy. Most cultural presentations of therapy (consider any number of popular films) portray client and therapist locked in a conversation about the past (childhood, adolescence, etc.).

With such an emphasis on these past-oriented questions, there is little room for imagining the future. The potential to sediment the past, to reify the story, and thereby make it static and immutable is tremendous. Probably more important, is the logic inherent in the therapeutic focus on the past. By focusing on what has already transpired, we unwittingly give credibility to causal models that are the hallmark of modernist science. We privilege the logic that claims that what went before causes what follows. So, for example, questions such as, “When did you first notice your homosexual tendencies?” or “How would you describe your childhood relationship with your mother/father?” imply that a client’s homosexuality is “caused” by some past event or relationship.

Constructionists do not necessarily want to argue for a disconnection between past, present and future. We simply want to raise the issue of narration. The past is always a story. And we all know that there are many ways to tell a story. Not only do we harbor many voices, each with a different set of possible narrations, but others involved in the same “history” will very likely narrate it differently.

Thus, the causality of past to present (and implied future) will take different turns, highlight different features, and pathologize or celebrate varied aspects depending on which story is privileged. This orientation allows us to wonder why we never ask when a client first noticed s/he was heterosexual. If we can understand the past cause for the “deviation” (notice a question arises concerning whose standard we are using when homosexuality becomes the “deviation”), we believe we can work toward resolution. Yet, there is never a need to explore a past cause for those practices that we value positively (i.e., heterosexuality).

One reason that future-oriented discourse can enhance relational engagement is because we all understand that we do not yet know the future. We have not embodied it. And thus, to the extent that we engage with others (our clients in this situation) in conversation about the future, we underscore the relational construction of our worlds. We fabricate together what we might live into [18].

This is not to suggest that talk of the past is wrong or emblematic of non-constructionist therapy. Instead of privileging a particular way to talk and/or particular themes or topics for therapy, constructionist therapy emphasizes the collaborative, situated creation of possibilities and one way to achieve this is with future-oriented discourse. In our talk of imagined futures, we invite coordination of many convergent and divergent understandings of the past and the present. Again, this form of relational engagement moves toward coordinated respect for multiplicity and difference. So, for example, questions like “How would you like to see homosexuality culturally situated in five years? What do you think you could do to help make that happen? What could others do? How could you help them?” place our focus on potential *action* – the (literal) making of a new reality – rather than a reification of the same old reality.

Languaging the ideal. Perhaps more than an additional theme, the notion of embodied languaging simply puts another description to our attempts to be relationally engaged. In addition to

being responsive in the interactive moment, entertaining ideal scenarios offers us a way to engage in dialogue with clients. Often we associate ideal talk with talk of the future. It is, after all, fantasy-like in that it is usually unknown – like the future. However, we can invite our clients to talk about how things would be for them in the present if the past had been ideal. Ideal talk can enhance relational engagement by honoring a painful or sedimented client story but offering a new way to talk about the past at the same time. Asking how things ideally would have been, should be, or might be does not disregard how they are presently narrated by a client and thus none of these options further pathologize the client. I am thinking here of Carla Guanaes's [19] research on group psychotherapy. She describes a client who offers a very well articulated story about how her problem was rooted in the past. In an attempt to help the client change, the therapist and other group members persistently offered many different interpretations about this client's past (e.g., maybe you were just lazy?, maybe you didn't really want to change?). The client could not accept these interpretations. She was convinced that her story of her problem was precisely how things really were. The more she referred to this horrible past that had made her mentally ill, the more the therapist and group members attempted to persuade her to give up her interpretation and look at the many other ways she could make sense of her situation.

It could be the case, however, that if the therapist and group had engaged this client in inquiry that was focused on how the story of her past would ideally be told, the client would have felt less pathologized. Perhaps to this client, the past was what it was. But asked how it could have ideally been is a very different sort of question. Had the group been sensitive to the significance of this story for the client, they might not have attempted to (essentially) tell her she was wrong. This attentiveness to the story of the client fosters a relational sensitivity. How might things be different if a therapist asks the couple of the scenario opening this article how they might imagine their present sexual relationship if the development of the sexual aspect of their marriage had been an ideal unfolding?

Perhaps such a question could ignite innovative and collaboratively constructed ideas about marital sexuality. Here, I am proposing relational sensitivity as an embodiment of the constructionist focus on language and conversational process. The suggestion here is simply that the language of the ideal can serve as a bridge between stories of despair and stories of hope.

Where do we go from here?

The significance, I think, of talking about diagnosis as a social construction is that it allows us to de-essentialize psychological problems. By locating meaning in the activities of persons rather than in their heads, social construction provides us with the resources for deconstructing pathology. If pathology emerges only in particular forms of practice, what might be the generative practices we could suggest in an attempt to move beyond pathology toward potential? This form of reconstruction draws heavily on the idea of polyvocality. We each harbor many voices; voices we acquire through our relations with others. Despite all the possible voices we have access to, that are familiar to us, that are omnipresent for our use, we surprisingly draw on the voices that have become our routine in situated moments. And yet, if we create meaning in relation with others, drawing on our “unheard” voices could invite the construction of diverse meanings. This becomes particularly useful when we confront difficulties or problems. *Changing the way we talk can change the reality within which we live.*

Thus, if the couple described in Scenario 1 at the opening of this article talk about their desire for sexual intimacy or lack thereof as a problem, they live within a reality of sexual problems. This problem-saturated reality invites a debate-mode of conversation where one partner tries to convince (persuade) the other that he has the “right” perspective on sexual intimacy while the other partner attempts to defend (and persuade) her position on sexual intimacy. Once languaged as a problem, it is difficult for this couple to find a way of going on together. Add to this the voice of the therapist who,

perhaps more often than not, assumes the expert voice. As an expert on problems associated with sexuality, the therapist steps into the role of arbitrator, navigating the troubled waters of spousal discord. Yet whose standards does the expert draw on in mediating this conflict? Are the standards of the expert's profession appropriate to this couple and their life-world? The constructionist account is not interested in determining what is objectively right or wrong but places more concern on creating the conversational conditions where different ways of talking and acting can emerge. The more clients and therapists explore the problem narratives that have brought the clients in to therapy, the more they realize (literally, make real) their impasse.

However, in addition to the voices we use in problematic situations, we also harbor the voice of possibility. It is interesting to note how dominant the voice of deficit, of assessment, of diagnosis is – particularly in the therapeutic context. It is time to reconsider forms of practice and relational communities where multiple participants, personal stories, self reflexive inquiry, and images of the future are given voice.

A Final Note: Deconstructing Sexuality

Constructionism focuses on what people do together, otherwise referred to as language practices. We must realize that language is a differentiating medium. When we select how we talk about sex, sexuality, and sexual identity, we use words that privilege certain traditions. For example, avoiding or banning talk of sexuality privileges the cultural belief that sex is private and perhaps a taboo topic – something that should only be discussed between consenting sexual partners. This secrecy or privatization of sexual talk implies that there is something wrong, bad, or distasteful about sexuality. If sex and sexuality are taboo topics, then those who openly express their sexuality, who do not reserve sexual talk for the private domain, are viewed as abnormal, perverted, or undisciplined. Yet, the belief that sex or sexuality as a non-pathological conversational possibility also emerges

within a community. Thus, to abstractly adjudicate which set of beliefs and values is “more correct” misses the possibility of coordinating multiple meanings. The challenge of coordinating multiple discourses about sexuality holds hope for the co-existence of diverse and often annihilating world views. For example, to recognize homosexuality as a “marked” category highlights how heterosexuality is the unquestioned, “unmarked” category. Each reality we construct with others obliterates the potential for alterior realities and serves to differentiate one group from another. With difference comes the tendency to avoid other realities; we keep our distance because the “other” is dangerous or threatening. Additionally, in the face of difference we tend to simplify our accounts of different realities rather than embrace the complex nature of their communal construction. We simply declare the oppositional view as wrong, or bad, or sick. Further, when we confront difference we are more apt to explain other realities in negative extremes. These tendencies move us toward division and conflict (as evidenced in the far right’s stigmatizing of gay identity and relegating sex in general to the category of the anathematized). How do we proceed in such a way that ever emerging antagonisms do not yield aggression, oppression and, basically the end of meaning? To the constructionist, what is rational and real are byproducts of relationship.

To examine the limits of sexual discourse is to examine the limits of relationship. Borrowing Wittgenstein's [20] notion of the language game, we begin to see within a constructionist discourse how any statement or activity is an invitation into a particular form of life. Social construction offers us some potential for moving beyond incommensurate realities toward a coordination of multiplicity.

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